ADULT SEPSIS PATHWAY

For patients under 16 years refer to the Sepsis in Children Clinical Guideline.
Use Febrile Neutropenia Guideline or Sepsis in Pregnancy Guideline where relevant.

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START if the patient looks very unwell or RDR observations indicate active deterioration

RECOGNISE

COULD IT BE SEPSIS?

*Sepsis is **infection** with **organ dysfunction** and is a **medical emergency**.*

Does the patient have any signs or symptoms of INFECTION?

- ☐ Looks very unwell
- ☐ History of fever, rigors, hypothermia
- ☐ Tachypnoea, shortness of breath, cough, new oxygen requirement
- ☐ New confusion, change in behaviour or altered level of consciousness, delirium
- ☐ Unexplained pain
- ☐ Wound or line redness, pain, swelling, exudate
- ☐ Non-blanching rash
- ☐ Abdominal pain, distension, vomiting, diarrhoea
- ☐ Dysuria, oliguria, frequency, odour
- ☐ Raised lactate, WCC or CRP (if known)

AND/OR at higher risk?

- ☐ Malnourished, frail, or older age
- ☐ Aboriginal and Torres Strait Islander people
- ☐ Indwelling medical device or line (or recently removed)
- ☐ Impaired immunity - chemotherapy, chronic illness, steroids, or diabetes
- ☐ Patient, carer, or family concern.
- ☐ Recent trauma, surgery, or procedure
- ☐ Known infection not responding to treatment
- ☐ Previous sepsis, re-presentation, deterioration, or no improvement with the same illness

Commence systematic assessment and document a full set of vital sign observations.

RESPOND & ESCALATE

Does the patient have signs of ORGAN DYSFUNCTION?

*Early signs include **hypotension, tachypnoea, altered mental state, raised lactate.***

☐ ANY PURPLE ZONE observation or lactate ≥ 4 mmol/L

↓

Medical Emergency Response call (as per RDR)
- ☐ Apply patient's end of life wishes if applicable
- ☐ Send bloods including lactate (if not already taken)

↓

Does the MER Team consider the patient has **PROBABLE SEPSIS?** *high risk of deterioration and **SEPTIC SHOCK**

NO →

YES ↓

☐ Two or more RED ZONE observations or lactate ≥ 2 mmol/L

and/or clinician or patient/family concern

↓

MDT review (as per RDR) including Senior Medical Officer
- ☐ Regional LHNs/ SAAS follow local escalation pathways
- ☐ Send bloods including lactate (if not already taken)

↓

Does the Senior Medical Officer consider the patient has **POSSIBLE SEPSIS?**

NO →

YES ↓

- Consider other causes of deterioration - MI, PE, DKA, GI bleed, acute pancreatitis, toxin ingestion or withdrawal.
- Continue frequent Rapid Detection and Response (RDR) observations.
- Reconsider sepsis if the patient continues to deteriorate.
- If infection treat with antibiotics.
- *Provide sepsis information if discharged home with infection.*

Commence sepsis treatment (over page) until proven otherwise
Consider specialist advice and site capability to care for critically unwell patient.
Discuss the management plan with the patient, Carer, or family, including any Advance Care Plan.

ADULT SEPSIS PATHWAY

SEPSIS IS TIME-CRITICAL
Complete actions 1 – 4 within 60 minutes with ongoing systematic assessment.

Regional LHNs: commence treatment, follow local escalation pathways, and consider early consult with MedSTAR - Ph 13 78 27.

RESUSCITATE

1. OXYGEN

WITHIN 30 min

- ☐ Commence immediately to maintain $SpO^2 \geq 95\%$ or 88-92% for COPD.

2. IV ACCESS & BLOOD CULTURES

- ☐ Vascular access – IV/IO.
- ☐ Blood Cultures x2 – from 2 separate sites - if CVAD, take 1 blood culture from CVAD & 1 set peripherally.
- ☐ BGL, **Lactate**, FBC, EUC, LFT's, CRP, and consider Coags.

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3. IV ANTIBIOTICS

- ☐ Commence within 60 minutes of identifying sepsis – refer to Therapeutic Guidelines: Antibiotic or local guidelines.
- ☐ Source of infection documented if known.
- ☐ Consider Infectious Disease Physician/Clinical Microbiologist review for complex patients or as required.

4. IV FLUIDS

WITHIN 60 min

- ☐ Crystalloid – Give 500mL bolus STAT - e.g., sodium chloride 0.9% or Hartmann's.
- ☐ Fluid input/output documented - consider IDC / hourly urine output.
- ☐ Repeat bolus if ongoing hypotension.

Consider commencement of vasopressors & ICU or hospital transfer if haemodynamic status not improving after fluid resuscitation.

REFER & REASSESS

5. MONITOR

- ☐ Closely monitor patients with cardiac or renal dysfunction, pulmonary oedema or frailty when repeating fluid boluses.
- ☐ Repeat lactate (within 2 hours) if initially elevated or condition changes - aim < 2mmol/L.
- ☐ Continue frequent monitoring of vital signs and urine output - Medical Officer review if urine <0.5mL/kg/hr.

6. REFER

- ☐ Consider escalation - Intensive Care / retrieval service transfer (Regional sites – liaise with SAAS/MedSTAR).
- ☐ Consider referral to Infectious Disease Physician, Senior Clinician or Sepsis Coordinator.

7. REASSESS

- ☐ Apply patient's end of life wishes if applicable.
- ☐ Ensure plans, goals of care and treatment options are discussed with patient and family.
- ☐ Review microbiology results and appropriateness of antibiotics as soon as possible.
- ☐ For persistent signs of sepsis, escalate to senior consultant, consider source control.

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